

**MISSOURI STATE BOARD OF HEALTH  
BUREAU OF VITAL STATISTICS  
CERTIFICATE OF DEATH**

Do not use this space.

27361

**1. PLACE OF DEATH**

County Jackson  
Township Law  
City Kansas City (No. 2216)

Registration District No. 000  
Primary Registration District No. Grave

File No. 3437  
Registered No. 3437  
St. Grave Ward

**2. FULL NAME**

Baby Smith

(a) Residence. No. 2216 Grave St. H Ward.

(Usual place of abode) (If nonresident give city or town and State)  
Length of residence in city or town where death occurred yrs. mos. 15 da. How long in U.S., if of foreign birth? yrs. mos. da.

**PERSONAL AND STATISTICAL PARTICULARS**

3. SEX Female 4. COLOR OR RACE Negro 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) new born

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OR (OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY AND YEAR) July 27-1928

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.  
15

8. OCCUPATION OF DECEASED  
(a) Trade, profession, or particular kind of work Child  
(b) General nature of industry, business, or establishment in which employed (or employer)  
(c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) Kansas City  
(STATE OR COUNTRY) Missouri

10. NAME OF FATHER James L. Smith

11. BIRTHPLACE OF FATHER (CITY OR TOWN) Bastrop  
(STATE OR COUNTRY) Texas

12. MAIDEN NAME OF MOTHER Mattie Duncan

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) Agass  
(STATE OR COUNTRY) Alabama

14. INFORMANT (Address) Mattie Smith  
2216 Grave

15. FILED 8.15.28 M. M. Crowe  
ISSR REGISTRAR

**MEDICAL CERTIFICATE OF DEATH**

16. DATE OF DEATH (MONTH, DAY AND YEAR) Aug 10 1928

17. I HEREBY CERTIFY That I attended deceased from July 27 1928, to Aug 10 1928 that I last saw him alive on Aug 9 1928, and that death occurred, on the date stated above, at 12:00 m.

THE CAUSE OF DEATH\* WAS AS FOLLOWS:  
Probably - Congenital Syphilis

34 (duration) yrs. mos. da.

CONTRIBUTORY (SECONDARY) 38 (duration) yrs. mos. da.

18. WHERE WAS DISEASE CONTRACTED  
IF NOT AT PLACE OF DEATH.....

DID AN OPERATION PRECEDE DEATH..... DATE OF.....  
WAS THERE AN AUTOPSY..... No

WHAT TEST CONFIRMED DIAGNOSIS Mother has Virus 4+  
(Signed) P. A. Kempel M. D.  
9.11.28 (Address) 934 Argyle Bldg K.C. Mo.

\*State the DISEASE CAUSING DEATH, or in (cases from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Pathological Laboratory  
Bell Memorial Hosp. K.C. Mo. DATE OF BURIAL 19

20. UNDERTAKER ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

